Physician-Focused Payment Model Technical Advisory Committee
Public Meeting Minutes

September 27, 2021
9:35 a.m. – 3:47 p.m. EDT
Virtual Meeting

Attendance*

Physician-Focused Payment Model Technical Advisory Committee (PTAC) Members

Jeffrey Bailet, MD, PTAC Chair (President and Chief Executive Officer, Altais)
Jay S. Feldstein, DO (President and Chief Executive Officer, Philadelphia College of Osteopathic Medicine)
Joshua M. Liao, MD, MSc (Associate Professor, Medicine and Director, Value and Systems Science Lab, University of Washington School of Medicine)
Kavita K. Patel, MD, MSHS (Nonresident Fellow, The Brookings Institution)
Angelo Sinopoli, MD (Consultant)
Bruce Steinwald, MBA (President, Bruce Steinwald Consulting)

PTAC Members in Partial Attendance

Terry L. Mills Jr., MD, MMM (Senior Vice President and Chief Medical Officer, CommunityCare)
Jennifer L. Wiler, MD, MBA (Chief Quality Officer Denver Metro, UCHealth, and Professor of Emergency Medicine, University of Colorado School of Medicine)

PTAC Members Not in Attendance

Paul N. Casale, MD, MPH, PTAC Vice Chair (Vice President, Population Health, NewYork-Presbyterian, Weill Cornell Medicine and Columbia University)
Lauran Hardin, MSN, FAAN (Senior Advisor, Partnership and Technical Assistance, National Center for Complex Health and Social Needs, Camden Coalition of Healthcare Providers)

Department of Health and Human Services (HHS) Guest Speakers

Elizabeth (Liz) Fowler, JD, PhD (Deputy CMS Administrator, and Center for Medicare and Medicaid Innovation [CMMI] Director)
Andrea Palm, MSW (Deputy Secretary of the Department of Health and Human Services [HHS])

Office of the Assistant Secretary for Planning and Evaluation (ASPE) Staff

Lisa Shats, PTAC Designated Federal Officer
Victoria Aysola, ASPE Staff

***Via Webex Webinar unless otherwise noted**

List of Speakers, Public Commenters, and Handouts

1. **Presentation: An Overview of Proposals Submitted to PTAC with Components Related to Social Determinants of Health (SDOH) and Equity and Other Background Information**

   Jay S. Feldstein, DO, Preliminary Comments Development Team (PCDT) Lead

   Handouts
   - Agenda
   - PCDT Presentation Slides
   - SDOH and Equity Overview Document
   - SDOH and Equity PTAC Proposal and CMMI Model Analysis

2. **PTAC Member Listening Session on Payment and Data Issues Related to SDOH and Equity**

   Joshua M. Liao, MD, MSc, University of Washington School of Medicine

   Handouts
   - PTAC Member Listening Session Presentation

3. **Listening Session on Payment and Data Issues Related to SDOH and Equity**

   Sarah L. Szanton, PhD, ANP, FAAN, Patricia M. Davidson Health Equity and Social Justice Endowed Professor, Director, Center on Innovative Care in Aging, Johns Hopkins School of Nursing (*Community Aging in Place – Advancing Better Living for Elders [CAPABLE] Provider-Focused Payment Model*)
   Kendell M. Cannon, MD, Clinical Assistant Professor, Stanford School of Medicine, CERC Scholar, Stanford Clinical Excellence Research Center (*Community Aging in Place – Advancing Better Living for Elders [CAPABLE] Provider-Focused Payment Model*)
   Michael Hochman, MD, MPH, Chief Executive Officer, Healthcare in Action (A SCAN Group Member Organization)
   Robert Phillips, MD, MSPH, Executive Director, The Center for Professionalism & Value in Health Care, American Board of Family Medicine Foundation
   Jacob Reider, MD, FAAFP, Chief Executive Officer, Huddle Health
   Toniann Richard, Chief Executive Officer, Health Care Collaborative of Rural Missouri

   Handouts
   - Subject Matter Expert Listening Session Presentation

4. **Panel Discussion with Subject Matter Experts (SMEs) on Payment and Data Issues Related to SDOH and Equity**

   Marshall Chin, MD, MPH, Richard Parrillo Family Professor of Healthcare Ethics in the Department of Medicine, University of Chicago (Academic/Policy Research Perspective)
   Karen Dale, RN, MSN, Market President, AmeriHealth Caritas District of Columbia, and Chief Diversity, Equity and Inclusion Officer, AmeriHealth Caritas Family of Companies (Payer Perspective)

Jennifer (Jen) E. DeVoe, MD, DPhil, John & Sherrie Saultz Professor and Chair, Department of Family Medicine, Oregon Health & Science University, Co-Director, BRIDGE-C2 Center (Provider Perspective)

Kathleen Noonan, JD, CEO, Camden Coalition of Healthcare Providers (Nonprofit Organization/Association Perspective)

LaQuana Palmer, MPA, Program Director, NCCARE360, Foundation for Health Leadership & Innovation (State Government Perspective)

Charlotte S. Yeh, MD, FACEP, Chief Medical Officer, AARP Services, Inc. (Patient Advocacy Perspective)

Handouts
- SDOH and Equity Panelist Biographies and Discussion Guide

5. **Public Commenters**

Jennifer Gasperini (Director of Regulatory Affairs, National Association of Accountable Care Organizations [NAACOS])

Jan de Maeseneer, MD, PhD (Professor, Ghent University, Belgium)

[NOTE: A transcript of all statements made by PTAC members and public commenters at this meeting is available on the ASPE PTAC website located at: https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee].

The ASPE PTAC website also includes copies of the presentation slides and other handouts, and a video recording of the September 27 PTAC public meeting.

Welcome and SDOH and Equity Session Overview

Jeffrey Bailet, PTAC Chair, welcomed members of the public to the September 27 virtual public meeting. He thanked providers, support staff, family members, caregivers, and PTAC stakeholders for their work supporting patients during the COVID-19 pandemic.

Chair Bailet noted that common themes have emerged across multiple proposals that have been submitted to PTAC. During the previous public meeting, the Committee explored issues related to care coordination in the context of Alternative Payment Models (APMs), resulting in a *Report to the Secretary* (RTS). During this public meeting, the Committee planned to examine how efforts to address social determinants of health (SDOH) and equity can be optimized in the context of APMs and physician-focused payment models (PFPMs).

Chair Bailet gave an overview of the day's agenda, including: remarks from the leadership team at the Department of Health and Human Services (HHS), a presentation by the Committee's SDOH and Equity Preliminary Comments Development Team (PCDT), a presentation by a PTAC member on addressing equity through APMs, a listening session with a previous PTAC proposal submitter (whose proposed model included components related to SDOH and/or equity) and subject matter experts (SMEs) on innovative initiatives and approaches to addressing SDOH and equity, a panel discussion with SMEs on data and payment issues related to SDOH and equity, a public comment period, and Committee discussion.

Chair Bailet introduced Elizabeth (Liz) Fowler, Centers for Medicare & Medicaid Services (CMS) Deputy Administrator and Center for Medicare and Medicaid Innovation (CMMI) Director.

Dr. Fowler provided an update on CMMI's strategy. She noted that in August, CMS leadership published a blog in Health Affairs describing the goals of CMMI's strategic refresh, which is intended to help drive delivery system transformation. Dr. Fowler indicated that meaningful transformation means having a delivery system that embraces the opportunity to advance health equity and address disparities in access and outcomes; structuring payments around value and quality instead of volume of services; and delivering person-centered care.

Dr. Fowler discussed CMMI's recent work related to charting a course for value-based payment. She noted that CMMI has been examining lessons learned from its first 10 years of work, during which CMMI has launched over 50 models. Dr. Fowler discussed several key lessons learned, including that CMMI's models have been predominantly Medicare-oriented and not very representative of the population's racial and ethnic makeup. She noted that only a limited number of CMMI's models have focused on Medicaid beneficiaries or included participation from safety net and rural providers. She indicated that going forward, equity will be central in every model; all models will be designed to include meaningful representation of beneficiaries from racial, ethnic, rural, and underserved populations, as well as the providers who care for them.

Dr. Fowler also discussed expert feedback that has indicated that the volume of models deployed by CMMI created complexities for both CMMI and model participants, particularly when models overlapped. She noted that in the future, CMMI is planning to launch fewer models that are more harmonized, consistent with CMMI's overarching strategy, and which, if certified for expansion, can be scaled to become part of the core Medicare and Medicaid programs. She expressed CMMI's commitment to identify and test approaches to reduce spending and improve quality of care and noted that CMMI will focus on a new approach to defining the success of models in terms of lasting transformation. Dr. Fowler explained that if CMMI finds that a model leads to fundamental changes and improvements in care delivery—even if it does not meet certification standards—CMMI will look for opportunities to incorporate successful elements of the model into Medicare, Medicaid, other models, or legislation.

Dr. Fowler expressed CMMI's commitment to increasing transparency; seeking diverse perspectives during model development, implementation, and evaluation, including patient and consumer feedback utilizing the Learning and Action Network (LAN) and other forms of engagement; and data sharing to gauge model progress and generate knowledge. Dr. Fowler noted that these lessons learned have informed the five objectives of CMMI's strategy: 1) drive accountable care; 2) advance health equity; 3) support innovation; 4) address affordability; and 5) partner to achieve system transformation.

Dr. Fowler noted that this public meeting on SDOH and equity was critical to CMMI's objective to advance health equity. She expressed that CMS is committed to developing a health care system that provides the highest level of health for everyone and eliminates health disparities, which will require centering equity in all stages of model design, operation, and evaluation. She expressed commitment to understanding the impact of CMMI models on all patients, which will require using patient-level demographic data, standardizing social needs data, and tracking data on penetration of models into underserved communities. Dr. Fowler announced that Dr. Dora Hughes was recently selected to be CMMI's Chief Medical Officer and will lead CMMI's work on health equity. Dr. Fowler noted that CMMI

will release more details on the new CMMI strategy, including ways to measure progress on each of CMMI's five objectives.

Dr. Fowler thanked Chair Bailet and Kavita Patel, whose terms are ending, for their hard work and dedication to the success of PTAC. She also thanked the Committee members for their time and dedication to furthering value-based care.

Chair Bailet thanked Dr. Fowler for her remarks and introduced Andrea Palm, Deputy Secretary of HHS.

Ms. Palm thanked Chair Bailet and Dr. Patel for their six years of service to PTAC, and the Committee members for their thoughtful reports. Ms. Palm also thanked health care workers and their partners for their efforts during the challenges of the COVID-19 pandemic. Ms. Palm noted that PTAC serves as an important venue for stakeholder ideas as the health care system transitions toward a value-based delivery system, and expressed appreciation for the Committee's choice of SDOH and equity for the public meeting theme. Ms. Palm discussed how the pandemic has been characterized by stark health inequities among racial and ethnic minorities, people with disabilities, and other vulnerable, at-risk populations. She raised the question of how to incorporate lessons learned from COVID-19 and build a more resilient, inclusive, and healthy society going forward.

Ms. Palm noted that President Biden tasked HHS with putting equity at the core of its work, and the Department seeks to build a country that can provide access to health care for everyone through the Build Back Better Framework. She noted that over 2.8 million people took advantage of the American Rescue Plan's lower health insurance premiums during this year's special enrollment period, and $19 million was distributed last month to strengthen telehealth services in rural and underserved communities. Ms. Palm noted that the Committee's *Telehealth Report to the Secretary* represented a thorough deliberation of the crucial role that telehealth plays in health care, its use in APMs, and considerations moving forward.

Ms. Palm emphasized the importance of narrowing health disparities by expanding the data available on race, ethnicity, primary language, sexual orientation, gender identity, geography, disabilities, and SDOH. She noted that in addition to gauging progress, these data can help strategically target health care efforts. Ms. Palm noted that efforts to infuse health equity into HHS programs include the human services aspects of the Department. She expressed an interest in supporting linkages across the health and social service sectors at the federal, state, and local level. She noted that clinicians need to be able to make referrals to local community-based organizations to support patients with housing, food, or transportation needs. She expressed a need to advocate for federal policies to address housing affordability, food security, transportation, and other aspects of SDOH. Ms. Palm emphasized the importance of working with other departments to promote health equity and address SDOH.

Ms. Palm noted that improving the health care delivery system and addressing health equity will require thoughtfully designed APMs and payment policies. She noted that CMMI is committed to working with physicians, health care leaders, patient groups, researchers, and other stakeholders to drive health care delivery system transformation. Ms. Palm emphasized that this transformation will require making a commitment to health equity, paying for value of care instead of volume of care, and re-engineering care delivery to deliver person-centered care.

Ms. Palm thanked the Committee members for their commitment to bettering the health care system, and their investments in the day's topic of SDOH and equity, as well as their prior work on telehealth and care coordination.

Chair Bailet thanked Ms. Palm for her remarks. He reminded stakeholders that PTAC accepts proposals on a rolling basis and indicated that the *Proposal Submission Instructions* and *Common APM Approaches Reference Guide* are also available on the ASPE PTAC website.

Chair Bailet invited Committee members to introduce themselves and their experience with SDOH and equity. After introductions, Chair Bailet introduced Jay Feldstein, the SDOH and Equity PCDT lead who presented the PCDT's findings from the background materials available on the ASPE PTAC website.

Presentation: An Overview of Proposals Submitted to PTAC That Included Components Related to SDOH and Equity and Other Highlights from Background Information

Dr. Feldstein noted that the three other members of the PCDT were Lauran Hardin, Angelo Sinopoli, and Jennifer Wiler. Referencing a slide presentation, Dr. Feldstein provided an overview of proposals submitted to PTAC that included components related to SDOH and/or equity, and other highlights from background information. Between 2016 and 2020, PTAC reviewed 35 proposed PFPMs. Of those, nine proposals included components related to SDOH—five of which also described strategies for advancing equity in access to care—and four proposals did not focus on SDOH but did address equity in some way. Dr. Feldstein noted that the PCDT's presentation would focus on a summary of the characteristics of the nine proposed models with components related to SDOH.

Dr. Feldstein provided an overview of the definitions associated with SDOH and equity that the PCDT used for their research, including definitions of SDOH, health-related social needs (HRSNs), behavioral health, health equity, and health disparities. This overview included that:
- The Agency for Healthcare Research and Quality's (AHRQ's) definition of SDOH defines them as community-level barriers patients can face to becoming and staying healthy, and which include five key areas: 1) social context; 2) economic context; 3) education; 4) physical infrastructure; and 5) health care context.
- There are medical and non-medical determinants of health, including socioeconomic factors, the physical environment, chronic disease and health behaviors, and health care access and quality.
- The relationship between health equity, SDOH, and HRSNs is best encompassed by a holistic view of health and health care, not only at the individual, community, state, and federal level, but also at the health care systems level.

Dr. Feldstein noted that efforts to address SDOH can assist in improving equity and reducing health disparities. He discussed examples of effective interventions for addressing SDOH and/or equity.
- Examples of interventions that have been found to be effective in addressing SDOH include supportive community-based interventions, anti-poverty interventions, and interventions targeting environmental conditions.
- Effective interventions for addressing SDOH that are relevant for health care providers include efforts to address patients' health care contexts and unmet social needs, such as culturally and linguistically competent care and education, and transportation services.
- Some health care providers have collected data on patients' SDOH and HRSNs and used this information to assist in referring patients to additional resources.

- Several programs have been effective in addressing HRSNs in the Medicare population, including programs that focus on housing and food insecurity.

Dr. Feldstein discussed the impact of the COVID-19 public health emergency (PHE) on the use of data related to SDOH and/or equity.
- While use of telehealth increased during COVID-19, research has highlighted disparities in access to telehealth.
- State and local health departments, health care organizations, and researchers used SDOH-related data to predict community risk for COVID-19.
- Health care organizations used SDOH-related data to improve care coordination.

Dr. Feldstein provided an overview of the incorporation of SDOH and/or equity in proposals submitted to PTAC.
- Five of the nine proposals identified as having an SDOH and/or equity component also described strategies for advancing equity in access to care.
- The nine selected proposals with an SDOH and/or equity component varied by clinical focus, setting of care, and care coordination context.
- Key areas (based on AHRQ's SDOH definition) addressed in the nine selected proposals included social context, health care context, and physical infrastructure.
- The most common SDOH-related functions in the nine proposals included monitoring progress and following up on identified HRSNs, improving integration of health care and social services and supports, and providing referrals to address HRSNs.

Dr. Feldstein provided an overview of CMMI models identified as having an SDOH and/or equity component.
- Fifteen CMMI models were identified as including SDOH and/or equity components, each of which addressed at least two of the five SDOH key areas identified by AHRQ.
- The 15 selected CMMI models targeted a diverse range of HRSNs, the most common of which were transportation problems, food insecurity, and housing instability.
- Almost all of the 15 selected CMMI models included a mental health component, and most addressed substance use. Six models also addressed physical wellness by empowering patients to lead a healthy lifestyle.
- Twelve of the 15 CMMI models identified as including SDOH and/or equity components have undergone evaluations. Some common findings across the evaluations included:
  - Many evaluations reported an increase in screenings for HRSNs and provider modifications to accommodate access to care issues from non-medical factors.
  - Some participating hospitals used data from screenings and population-level characteristics to open resource centers or training programs to address SDOH.
  - Model participants increased the number of social workers and other community service staff.
  - A lack of sufficient financial resources and personnel to provide patient-centered, value-base care on a large scale was a common challenge, which was intensified in rural and historically disadvantaged communities.
- Five of the 15 selected CMMI models included performance measures related to SDOH and/or equity. These performance measures varied in scope.

Dr. Feldstein discussed the current state of evidence on the effectiveness of SDOH interventions relevant to APMs.

- Successful patient-level interventions by health care providers to address HRSNs related to patients' health care contexts (based on AHRQ's SDOH definition) often included provision of culturally and linguistically competent care and education; improved financial access to care; and improved communication, navigation, and self-management.
- Health care providers are well-positioned to assist patients in accessing community-based benefits and services.
- Health care providers can also engage with local community leaders to advocate for policies and interventions for addressing SDOH such as increasing wages and improving environmental conditions.

Dr. Feldstein discussed trends in the use of SDOH and/or equity data for reimbursement at the federal and state level, and among commercial insurers.

- At the federal level:
  - CMMI has designed and implemented APMs that address SDOH and/or equity.
  - Medicare Advantage (MA) plans may expand health-related supplemental benefits to include services such as meal delivery and transportation assistance.
  - Medicare's value-based purchasing programs do not currently include health equity measures to reduce beneficiary disparities.
- At the state level:
  - Section 1915 Medicaid waivers can cover home-based care, and Section 1115 Medicaid demonstration waivers can cover non-medical care.
  - Medicaid managed care organizations can engage in activities to address SDOH.
- While there has been limited progress among commercial insurers to incorporate SDOH and/or equity into payment methodologies, Aetna has created SDOH indexes.

Dr. Feldstein discussed areas where additional research is needed in order to optimize efforts to address SDOH and/or equity in APMs and PFPMs, such as data needs, provider incentives, quality and effectiveness measurements, and community-wide interventions.

PTAC Member Listening Session on Payment and Data Issues Related to SDOH and Equity

Josh Liao presented slides on addressing equity through APMs. Dr. Liao noted that his presentation would focus on his research on episode-based bundled payment models, and how these concepts can be applied to APMs more generally. He described the context for his research.

- APMs have played an important role in informing expectations and signaling direction toward value-based care. APMs are diverse and differ in magnitude of effectiveness.
- Progress in improving care delivery has not necessarily translated into progress in addressing health disparities.
- There are reasons for concern that APMs could worsen existing health disparities faced by marginalized groups.

Dr. Liao noted that he will explore how APMs have engaged marginalized communities, how APMs have affected disparities among individuals in these communities, and how to advance equity through APMs. He explained that selective participation in APMs creates a situation where organizations that choose to participate may be fundamentally different than those that do not. Among those that participate, there could be selection bias in which patients receive care and what types of care they receive.

Dr. Liao outlined the takeaways he hoped to convey during his presentation.
- Some APMs have excluded historically marginalized communities.
- Despite encouraging early evidence, there is a dearth of data about how APMs impact disparities among historically marginalized populations.
- Changes that could be made to advance equity through APMs include setting national policy goals, incorporating equity into APM evaluations, and convening multi-stakeholder groups to guide agendas for achieving equity goals.

Dr. Liao discussed how APMs have engaged historically with marginalized communities.
- Dr. Liao provided an overview of a study on the Comprehensive Care for Joint Replacement (CJR) model, which examined the relationship between the number of dual eligible beneficiaries in geographic areas around the country and selection for participation in the CJR APM. The study found that markets with a higher proportion of dual eligible beneficiaries were less likely to participate in CJR. He noted that the selection criteria for CJR did not consider SDOH or social risk factors, including income or dual eligibility status. Dr. Liao explained that while the CJR model yielded benefits to communities and individuals in participating regions, individuals not included in those participating markets, such as dual eligible beneficiaries, may not have benefited. He added that when researchers interpret findings from the CJR model, they should be careful about generalizing to communities with higher proportions of dual eligible beneficiaries.
- Dr. Liao noted that in general, mandatory APMs have the potential for greater geographic coverage, more generalizable impacts, less selective participation, and less selection bias. However, the research presented on the CJR model suggests that mandatory APMs may not realize this potential if they are not designed to directly consider social risk factors, and that this research finding may be relevant for future payment model design and policy. Dr. Liao noted that he is currently studying the effects of mandatory APMs (such as the CJR model) compared to voluntary APMs (such as the Bundled Payments for Care Improvement [BPCI] model). He noted that through this research, he has observed different strengths of association between certain SDOH variables and model participation in mandatory versus voluntary APMs.
- Dr. Liao discussed other research on geographic participation among Accountable Care Organizations (ACOs), which found that rates of ACO participation by physicians were lower in areas where higher percentages of the population were Black, living in poverty, disabled, or less educated. He noted that this study highlights that geographic inclusion or exclusion is important in evaluating the effects of APMs on SDOH more broadly, not just in bundled payment models.
- Dr. Liao emphasized the importance of considering SDOH and participation mechanisms in APM design.

Dr. Liao discussed how APMs have affected disparities among individuals in marginalized communities.
- Dr. Liao provided an overview of preliminary results from a study on how certain groups with high clinical or social risk fare within the BPCI model. This study found that there were differential, positive effects observed among certain high-risk groups, such that the likelihood of certain events was lower, including 90-day readmissions, 90-day mortality, and discharge to a skilled nursing facility (SNF). Ultimately, the study observed no widened disparities for high-risk patients under voluntary bundled payment models and found that strategies used in bundled payments did not appear to be applied indiscriminately to high-risk patients. Dr. Liao noted that while this early evidence is positive, more research is needed to study disparities within APMs.

- Dr. Liao highlighted the difference between considering the disparities between individuals in an APM compared to those not in an APM, versus looking at the disparities between individuals within an APM.

Dr. Liao discussed three ways to better advance equity through APMs: explicitly addressing equity in national policy design and implementation; incorporating equity into APM evaluations; and convening multi-stakeholder groups to guide an agenda for achieving equity goals. Dr. Liao described the goals of the new Health Equity and Payment Initiative: setting longitudinal policy goals, identifying changes needed in measurement and evaluation methods, and implementing and evaluating programs.

Chair Bailet invited Committee members to ask questions about Dr. Liao's presentation.
- Dr. Wiler asked about the role of risk adjustment in eliminating model or pilot selection bias and whether there are any best practices around risk adjustment.
  - Dr. Liao noted that mandating participation based on certain dimensions such as historical volume or spending is important but may not yield generalizable results if other dimensions are not considered. He noted the importance of considering selection criteria and quality measures when designing programs. Regarding risk adjustments, he added that there is research around adjusting payments to ensure that patients and physicians are not adversely affected, but the issue has not been fully resolved.
- Bruce Steinwald asked for Dr. Liao's thoughts on how reimbursements should change to advance SDOH and equity, and if relying on Medicare fee-for-service (FFS) limits can be accomplished.
  - Dr. Liao noted that prospective payments and care management fees could help achieve SDOH and equity goals, especially as they impact how specialty and non-specialty care relate to one another within APMs.
- Dr. Patel asked about whether MA plans, which may have more flexibility to address SDOH and equity, generate any spillover effects in terms of patients within a region who are not enrolled in an MA plan but are nonetheless benefiting due to broader practice shifts among plans in that region as a result of MA market penetration.
  - Dr. Liao noted that research has observed spillover effects from, for example, the BPCI program, with observed spillover effects in MA patients and patients under commercial insurance plans, which highlights the importance of taking a multi-payer approach. He also noted the importance of better engaging beneficiaries in APMS.
- Chair Bailet asked whether Dr. Liao has observed disparate impacts by practice type such as system versus independent or urban versus rural.
  - Dr. Liao noted that in the CJR model, studies have found that safety net hospitals are less likely to receive shared savings, and in the BPCI model, studies are finding inconsistent effects for safety net hospitals. He noted that when designing future mandatory models, it will be critical to consider provider type. He raised the issue of whether practices should be defined as "safety net" based on the population they care for.
  - Chair Bailet noted that ensuring that SDOH-related services are delivered appropriately to patients and not solely the responsibility of the health care practitioner is an important challenge.

Listening Session on Payment and Data Issues Related to SDOH and Equity

Chair Bailet moderated the listening session with previous submitters and SMEs. He invited each of the presenters to introduce themselves, noting that full biographies and presentations for presenters can be found on the [ASPE PTAC website](#):

Previous Submitters
- Sarah L. Szanton, PhD, ANP, FAAN, Patricia M. Davidson Health Equity and Social Justice Endowed Professor, Director, Center on Innovative Care in Aging, Johns Hopkins School of Nursing (*Community Aging in Place – Advancing Better Living for Elders [CAPABLE] Provider-Focused Payment Model*)
- Kendell M. Cannon, MD, Clinical Assistant Professor, Stanford School of Medicine, CERC Scholar, Stanford Clinical Excellence Research Center: Community Aging in Place (*Advancing Better Living for Elders [CAPABLE] Provider-Focused Payment Model* proposal)

SMEs
- Jacob Reider, MD, FAAFP, Chief Executive Officer, Huddle Health
- Robert Phillips, MD, MSPH, Executive Director, The Center for Professionalism & Value in Health Care, American Board of Family Medicine Foundation
- Toniann Richard, Chief Executive Officer, Health Care Collaborative of Rural Missouri
- Michael Hochman, MD, MPH, Chief Executive Officer, Healthcare in Action (A SCAN Group Member Organization)

Sarah Szanton and Kendell Cannon presented on the *CAPABLE* model, including findings related to reduced disability, improvements in SDOH, and cost savings.
- Dr. Szanton emphasized the role of *CAPABLE*'s multidisciplinary team (including a nurse, occupational therapist, handy worker, and the participant) in addressing SDOH that are important to the participant's quality of life and in helping them avoid a nursing home and hospital stay. The model, Dr. Szanton added, addresses health equity and SDOH through standardized tailoring of care to the patient's own goals, building their self-efficacy, using an integrated team, and generating data that APMs can use to address SDOH and advance health equity.
- Dr. Szanton noted that the *CAPABLE* model does not focus on a particular disease, is client-driven instead of provider-driven, focuses on the person-environment fit instead of narrow risk factors, and is self-sustaining for long-term impact.
- Recent evidence from analysis of the *CAPABLE* model's impact on Medicare costs among dual eligible beneficiaries found a decrease in per member per month (PMPM) costs during a two-year period.[1] Dr. Szanton explained that this reduction is possibly due to disability being under-assessed in traditional models and a big driver of costs in hospitalizations and nursing home admissions. She noted that modifiable disability is highly predictive, identifiable with the right data (e.g., asking people if they have difficulty with breathing or exercise), and treatable. She also noted that, on average, patients in the CAPABLE model show reduced disability. Dr. Szanton noted that *CAPABLE* is now operational in 45 sites, including some APMs, and a new paper was recently published on all of the studies of *CAPABLE*.

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[1] In the [*CAPABLE* Report to the Secretary](#), Committee members expressed concerns regarding possible impacts of the *CAPABLE* model on costs, noting a lack of clear evidence of impact on total cost of care and research to date that does not show statistically significant reductions in cost.

- Dr. Szanton highlighted the role of physical function as a health equity indicator, and described recent findings by HHS that functional status is a crucial variable not currently included in risk adjustment. She described how using data to target patients and develop tailored care plans according to their functional status will help APMs address SDOH and improve health equity.

Chair Bailet invited Committee members to ask Dr. Szanton and Dr. Cannon questions.
- Dr. Feldstein asked about the operational workflow for enrolling people into the program.
  - Dr. Szanton clarified that patients are identified through the annual wellness visit, which has functional questions about disability. She noted that data screens using claims are less useful, since physical function is often under-documented in claims due to not necessarily being billable. Dr. Szanton also noted that the National Quality Forum (NQF) and CMS are moving forward with trying to require assessments of physical function.
- Chair Bailet asked whether Dr. Szanton and Dr. Cannon have experience with predictive analytic engines to use data for proactive outreach to certain populations.
  - Dr. Szanton noted that some of the larger partners *CAPABLE* works with (e.g., VillageMD) will be using predictive analytics, and the team hopes to learn more about how this might impact patient outcomes and tailored care approaches.
- Dr. Sinopoli asked whether the nurse on the CAPABLE care team also completes assessments or connects with external care managers or community-based organizations to assist with other identifiable issues.
  - Dr. Szanton clarified that the CAPABLE assessment completed by the nurse includes pain, mood, strength, balance, medication, falls, connection with a primary care provider (PCP), and other items that the participant is interested in (e.g., pain, depression). The nurse may identify other issues that they then refer back to the PCP. Dr. Szanton noted that the program often hears from primary care teams within Johns Hopkins' all-payer model about how valuable it is to receive this information.
  - Dr. Cannon added that the data generated from these assessments are extremely valuable to clinicians in terms of what they can do to improve overall health outcomes.
- Dr. Liao asked where cost savings are observed.
  - Dr. Szanton explained that the reduction in nursing home admissions has been enough to break even for the program, but the savings from reductions in hospitalizations have been the greatest source of cost savings. She noted that there were also savings associated with specialty care, and indicated that only home health care costs increased.
- Mr. Steinwald asked how common it is that the provider-based organizations (hospitals, or organizations that include both hospital and nursing) support the program with less usage of their facilities.
  - Dr. Szanton clarified that unless a whole unit is shut down, money is not saved because there are still staff and overhead costs, and the savings are more for Medicare than for the hospital.

Jacob Reider presented on work of the Healthy Alliance Independent Physician Association (HA-IPA) organization to use data to address SDOH.
- Dr. Reider explained that HA-IPA is a daughter organization of Alliance for Better Health, which was created in 2015 as a product of the 1115 Delivery System Reform Incentive Payment (DSRIP) Program waiver granted to New York state in 2014. He described how the organization's approach has evolved from relying on care delivery organizations to reduce its Medicaid utilization, to addressing the "upstream" community-based needs (i.e., social and related needs)

that drive health, and acknowledging that achieving better health is a shared commitment, and that information technology is an important component of success.

- Dr. Reider described HA-IPA's areas of focus, including: engaging with a local food pantry network in a closed-loop referral system to address food insecurity and, through data sharing with the food providers, to identify and address other social issues; implementing "food as medicine" initiatives; and providing transportation for non-medical activities. Additionally, Dr. Reider noted that partnering with regional hospitals to create respite centers for individuals experiencing homelessness and that certifying peer recovery advocates to assist individuals with substance use disorders (SUDs) have been found to reduce hospital readmissions and preventable ED utilization, respectively.
- Dr. Reider described the closed-loop referral system implemented by HA-IPA, which includes over 100 medical and community-based organizations, and which uses a common screening tool that all organizations within the system use and access to obtain the resulting data. He emphasized that the common screening tool and shared data are crucial for enabling participating organizations to act based on the screening results. He noted that the system relies on a central data warehouse and analytic tools that enable HA-IPA to act on the available data to adjust its community-level approach. He noted that siloes are an obstacle to this community-level approach, and instead recommended a public utility model that spans the community, and where activities are agnostic to where the funding is coming from.

Chair Bailet invited Committee members to ask Dr. Reider questions.
- Mr. Steinwald asked whether there was pushback from provider organizations as HA-IPA achieved a certain level of success in the community.
  - o Dr. Reider explained that there was no pushback, and that the most significant response has been acquiescence. He noted that health care partners are interested in what HA-IPA is doing and are in some cases embracing initiatives that improve return on investment, such as the respite program, which has reduced 30-day readmissions. He noted that aligned business incentives help forge positive partnerships.
- Dr. Sinopoli asked whether Dr. Reider could speak more about the screening tool.
  - o Dr. Reider explained that HA-IPA uses the Health Leads screening tool, which was selected by the community.

Robert Phillips presented on the role of big data tools and point of care solutions to address social risk and equity.
- Dr. Phillips noted that his presentation was based on a Health Affairs blog produced following a workshop with federal and other stakeholders in January 2021 in response to the 2014 IMPACT Act, which prompted stakeholders to consider whether and how payments should be adjusted for social risk.
- Dr. Phillips noted challenges with capturing SDOH data at the point of care in clinical care, including that less than 4 percent of visits have Z codes for SDOH, and while MA plans are capturing SDOH best, none of them have adjusted payments. He explained that practices are not equipped or funded to manage social needs and emphasized the importance of lowering the burden of screening and allocating resources where they are most needed.
- Dr. Phillips noted that the United Kingdom (UK) and New Zealand use big data to measure social need by assessing risk and assigning payment within small geographic areas; identifying individual patient or community needs; and using those identified needs to allocate resources. He highlighted the English Index of Multiple Deprivation, which adjusts for social services and

clinical payments using a set of social determinants that are weighted based on their impact on outcomes and used to develop a payment scheme assigned to the index and geography. He added that hospital care utilization is higher and life expectancy is lower for those in the most deprived quintiles.

- Dr. Phillips listed the UK National Health Service's (NHS') criteria for its funding formulas, including that they should be based on universally available and validated data, reflective of underlying social and medical needs in a locality, independent of previous spending in a locality, scientifically coherent and plausible, feasible with a low administrative cost, not vulnerable to fraud, transparent, and reflective of policy intentions. These criteria include an equity criterion, which is focused on reducing avoidable health inequities. The NHS allocates payments with a weight per head 10 times higher for areas with greater socioeconomic deprivation.
- Dr. Phillips added that New Zealand has implemented a similar Socioeconomic Deprivation Index and allocates funding proportionately according to measured deprivation.
- Dr. Philips noted that the United States has similar capacity. He mentioned the Area Deprivation Index (ADI) developed by the Health Resources and Services Administration (HRSA) and recently updated by the University of Wisconsin, which measures geospatial metrics of neighborhood disadvantage that are robust, translatable, and yet underutilized. The ADI includes 17 education, employment, housing-quality, and poverty measures.
- Dr. Phillips discussed the Population Health Assessment Engine (PHATE), which identifies individual patient risk based on where they live and assesses communities for community-based interventions. PHATE uses electronic health records (EHRs) and community data to map physician or clinic service areas, display "community vital signs," and identify community partners. He noted that experts behind PHATE are preparing to align SDOH-adjusted payments with tools to identify patients with social needs. Dr. Philips noted that physicians should still ask patients about their social needs. He added that Massachusetts is the only state to use an ecologic measure of risk that includes individual- and neighborhood-level variables to create an index by which it allocates Medicaid managed care payments.
- Dr. Phillips provided an overview of suggested policy objectives, including that:
  - o Payment adjustments should be proportional to the area of disadvantage and designed to address social needs, not just the usual related health care costs.
  - o Geographic, small area indices should be utilized so that there is a close association to the person level.
  - o Payment policies should reduce burden on providers, payers, and states, and reduce inequities between states.
  - o Funders should predefine the goals of reduced total costs and improved patient health outcomes, and use these to titrate funding and create accountability for how the funds are used.

Chair Bailet invited Committee members to ask Dr. Phillips questions.
- Dr. Sinopoli asked whether the physician practice area is utilized to assign community health workers (CHWs).
  - o Dr. Phillips explained that assigning community health workers is the goal. He noted that a residency practice in Lawrence, Massachusetts, used the PHATE tool to define its clinical service area for its population by combining it with data on patients who had been screened for food insecurity. The practice used these data to create mobile food pantries and send them to specific locations to meet local need.

Toniann Richard presented on the Health Care Collaborative (HCC) of Rural Missouri.
- Ms. Richard introduced the HCC, a vertically integrated health care network located in west-central Missouri focused on rural health care. The HCC has five Federally Qualified Health Center (FQHC) locations, three mobile units, several school-based programs, and nursing home access points. The HCC uses the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool to capture SDOH data within its EHR and ensure follow-up by CHWs. Ms. Richard additionally noted that the HCC uses the Extension for Community Healthcare Outcomes (ECHO) telemedicine network through the University of Missouri to consult with CHWs to help address community-level issues, such as financial wellness.
- Ms. Richard described some approaches to strategic planning for engaged partnerships, including holding conversations with Chief Financial Officers (CFOs) early in the process; advocating with health plans about paying for necessary services; using the PRAPARE tool assessment to identify issues, offer enabling services, and receive payment; and working with funders and development officers developing payment strategies that support non-billable positions.
- Ms. Richard emphasized that collaboration takes time, and it is important to find the right provider partner. She added that after working with a number of providers, it became clear that the risk assessment tool was too burdensome. Ms. Richard added that it is also important to find the right community partners, and to ensure that all service partners are working together, especially when advocating for non-billable services for a patient.
- Ms. Richard added that the HCC uses the Institute for Healthcare Improvement (IHI) Plan Do Study Act (PDSA) model to improve clinical and community performance, and to use in operational implementation. She listed some areas for consideration when working in rural health care collaboration and coordination, including analyzing the environment, engaging with potential partners, and developing a collective strategy using a return-on-investment model.
- Ms. Richard concluded with a summary of the HCC's planned next steps, which include working with regional hospitals on emergency room discharge planning, addressing short-term housing needs, and updating their EHR to allow CHWs and peer recovery coaches to document needs in a way that avoids liability for licensed health care providers.

Michael Hochman presented on primary care for patients experiencing homelessness.
- Dr. Hochman presented on Healthcare in Action (HIA), a new medical group funded by the SCAN Health Plan for patients experiencing homelessness.
- Dr. Hochman noted that the fundamental challenges for patients experiencing homelessness include member pain points (i.e., social challenges, access challenges, and disjointed care) and provider pain points (i.e., limited data, disrupted operations such as high no-show rates and limited phone access, unexpected/unanticipated needs, and financial losses). He added that while homelessness impacts nearly every racial/ethnic and demographic group, it disproportionately impacts those who have historically faced discrimination in the U.S.
- Dr. Hochman introduced the street medicine model of care. Instead of operating in offices, street medicine teams go to patients where they are and follow them longitudinally wherever they may end up (e.g., hospitals). He added that street medicine relies upon charitable funding, and he is not aware of any self-sustaining model.
- Dr. Hochman explained that the vision for HIA is to combine street medicine with managed care to produce a sustainable health care model for adults experiencing homelessness. He noted that the program is targeting a launch date of January 2022.

- Dr. Hochman explained that the scope of services will include clinical care services (full scope primary care; clinical care management; ambulatory, mental health, and substance use care) and wrap-around services (care management, social work support, transportation to social services and appointments, and longitudinal care). He added that HIA hopes to move to professional risk in the future.
- Dr. Hochman explained that the primary care street team includes nurse practitioners, physician assistants, peer navigators with lived homelessness experience, and a social worker to assist patients with navigating systems such as housing. He added that the cost of the team is more expensive than a primary care team, and the program will be more expensive than a traditional primary care model. He noted that HIA is aiming to use managed care prospective payments to fund this model to reduce FFS billing burden.
- Dr. Hochman described the business model for the HIA group. One approach is a per-member capitation of $10,000 for the street medicine programs. He added that the annual health care costs for dual eligible SCAN members experiencing homelessness is currently around $60,000. The goal of the HIA intervention is to reduce costs by around 25 percent ($15,000) through hospital avoidance. Another approach is a global capitation approach that provides enhanced funding for health-related social services, a payment adjustment factor for patients experiencing homelessness, and flexibility in the performance and outcome metrics used to assess care quality, such as the introduction of social measures.

Chair Bailet invited Committee members to ask Dr. Hochman questions.
- Dr. Feldstein asked how many SCAN members are experiencing homelessness.
  - Dr. Hochman explained that around 350 SCAN members throughout California, including 200 in Los Angeles, are experiencing homelessness. He added that in order to achieve economies of scale, the program hopes to secure contracts with other health care plans.
- Dr. Feldstein asked whether HIA attempts to enroll uninsured members in health plans (e.g., Medicaid).
  - Dr. Hochman confirmed that HIA and SCAN plan to work to enroll uninsured patients in health plans, including Medicaid.

Panel Discussion with SMEs on Payment and Data Issues Related to SDOH and Equity

Chair Bailet moderated the panel discussion of SMEs representing different perspectives on payment and data issues related to SDOH and equity. He invited each of the participating panelists to introduce themselves, noting that full biographies of each panelist can be found on the [ASPE PTAC website.](#)
- Marshall Chin, MD, MPH, Richard Parrillo Family Professor of Healthcare Ethics in the Department of Medicine, University of Chicago (Academic/Policy Research Perspective)
- Karen Dale, RN, MSN, Market President, AmeriHealth Caritas District of Columbia, and Chief Diversity, Equity and Inclusion Officer, AmeriHealth Caritas Family of Companies (Payer Perspective)
- Jennifer (Jen) E. DeVoe, MD, DPhil, John & Sherrie Saultz Professor and Chair, Department of Family Medicine, Oregon Health & Science University, Co-Director, BRIDGE-C2 Center (Provider Perspective)
- Kathleen Noonan, JD, CEO, Camden Coalition of Healthcare Providers (Nonprofit Organization/Association Perspective)
- LaQuana Palmer, MPA, Program Director, NCCARE360, Foundation for Health Leadership & Innovation (State Government Perspective)

- Charlotte S. Yeh, MD, FACEP, Chief Medical Officer, AARP Services, Inc. (Patient Advocacy Perspective)

The panelists were asked to share their perspectives on the role and objectives of SDOH and health equity in the context of value-based care; specific lessons for addressing equity and SDOH during the COVID-19 PHE; optimizing value-based care delivery in APMs and PFPMs through the collection and use of SDOH and equity-related data; performance measurement and reimbursement of SDOH and equity-related initiatives; and any additional critical insights about SDOH and equity in APMs and PFPMs. The following are highlights of some of the key themes that were discussed by each panelist.

- Marshall Chin explained that there are three principles to keep in mind when discussing SDOH and equity: to continually connect the dots (e.g., how payment reform incentivizes care transformation that addresses a person's medical and social needs to advance health equity); to keep patients and communities central and maintain flexibility to adapt to different contexts (e.g., co-creating and implementing solutions with communities); and to address structural, technical, personal, and cultural issues together. He added that addressing all four sets of issues helps with implementation buy-in.

  Dr. Chin noted that the COVID-19 PHE demonstrated that the public cares about health equity and gave rise to a greater awakening and understanding of these inequities. He noted that the COVID-19 PHE also led to disruptive innovation within health care to create workarounds for issues such as the reimbursement of telehealth or expansion of scope and practice, breaking years of political and organizational roadblocks. He suggested that the COVID-19 PHE demonstrates that policy makers and providers can create disruptive change.

  Dr. Chin suggested that interventions that enable close relationships and systems, support holistic care, and allow follow-up and monitoring are effective interventions for addressing SDOH. He added that it is important to spend time with patients, understand their medical and social needs, and offer team-based care to support care across the continuum of health and social services while accounting for social deprivation. He mentioned two recent National Academies of Sciences, Engineering, and Medicine reports on high-quality primary care and the future of nursing that emphasize addressing SDOH and health equity, including the types of systems and payment reforms needed to support these efforts. Dr. Chin recommended support for care navigators and CHWs. He added that data are critical for identifying issues, designing interventions, and linking them to reimbursement to incentivize efforts. Dr. Chin also emphasized using measures that are new to health care but are important for population health, such as high school graduation rates and measures of community and social cohesion.

  Dr. Chin described three levers to use in payment mechanisms. The first lever is rewarding improvements for less advantaged populations and reductions in disparities. Second, providing flexible upfront payments to fund infrastructure necessary to address SDOH and equity (e.g., new personnel, information exchange), foster community partnerships between the health care sector and social services with upfront funding, and align efforts across payers, and creatively blending and braiding funding to support cross-sectoral initiatives. Third, providing more resources for safety net providers through tools such as risk adjustments to prevent them from losing money within APMs.

Dr. Chin explained that he runs one of the Robert Wood Johnson Foundation's major health equity programs. He shared four aspects that he feels are on the cutting edge of equity: aligning the four major stakeholders (payers, health plans, health care delivery organizations, and patients and communities); increasing focus on patients and communities; addressing structural racism; and integrating payment reform, technical assistance, and discussions around racism, culture, justice, and ethics. He noted that unless these discussions are held, advancing health equity will not be prioritized.

- LaQuana Palmer noted that before North Carolina could begin thinking about value-based care, the state had to build an electronic and coordinated care network to link health and human services together; this network is called NCCARE360. Ms. Palmer explained that the 1115 waiver demonstration granted to North Carolina by CMS in 2019 has funded NCCARE360 and allowed the state to pay for services delivered to address unmet social needs. She noted that when developing NCCARE360, the state aimed to build an infrastructure that would allow communities, providers, and payers to communicate, and she emphasized the importance of developing an infrastructure before considering value-based payment models.

  Ms. Palmer noted that she previously worked in the division of Public Health Preparedness & Response and was trained in how to respond to a PHE. During COVID-19, her organization identified communities that had access issues and functional needs. She noted that the organization had to expedite the rollout for NCCARE360 to create interoperability between community service organizations, health care systems, the department of health, and other public health workers during the COVID-19 PHE. It implemented the network statewide by June 2020. At the same time, the government was building a workforce of CHWs, and a COVID-19 support program that was then onboarded onto NCCARE360. The COVID-19 support program included initiatives such as income support and resource availability that CHWs on the ground could use to help individuals living in quarantine. She added that her organization was able to link people to the services they needed under an FFS model and to use CARES Act funds to connect individuals to the resources they needed during the COVID-19 PHE. Ms. Palmer added that it also used NCCARE360 to send messages and information about testing sites and vaccines to ensure that individual patients were connected to programs across the state.

  Ms. Palmer noted that North Carolina embeds SDOH screening questions in NCCARE360, and that these questions are shared throughout the state. She added that patients are being asked these questions in the health- and non-health-care settings (e.g., social worker offices, schools), and emphasized the importance of ensuring that providers are comfortable asking these questions. Ms. Palmer noted that in the past, the focus has been on addressing medical needs, but addressing non-medical and unmet social needs should be done concurrently. She described how this increase in scope and focus creates capacity challenges in terms of having enough staff who are comfortable asking these questions and can ask these questions effectively. She added that it is important to address such capacity challenges before using the data to track outcomes meaningfully.

  Ms. Palmer added that it is important to consider grassroots community-based organizations' infrastructure when designing services and systems to address SDOH. She noted that NCCARE360 uses capacity-building funds to help organizations doing grassroots work for the community. She emphasized the importance of community investments to make sure links are made between identified needs and resources.

Ms. Palmer described the importance of support for frontline staff collecting SDOH information, and the need for training around trauma-informed care to combat people's fears about soliciting and/or disclosing certain information. She added that staff should receive comprehensive risk-counseling services training to be prepared to ask these questions. These trainings will help build trust between frontline staff and patients. She noted that sometimes staff are afraid to ask questions related to race and then input data based on assumptions, which in turn, skews the data.

- Jennifer (Jen) DeVoe emphasized the importance of connecting the dots and keeping patients and communities central. She added that while strong primary care is the foundation of the health care system, it is important to ensure that primary care teams are not the only stakeholders addressing a patient's social needs: the entire health care system should. Dr. DeVoe raised the concern that the limited amount of health care reimbursement (5 percent) allocated to primary care would be an insufficient funding resource for connecting systems and identifying social needs and risks. She added that she is optimistic that stakeholders are looking at the other 95 percent of reimbursement to consider where that funding goes downstream, how to address diverse health-related social needs such as housing and employment, and how to build a more robust cross-sectoral infrastructure.

  Dr. DeVoe suggested that providers consider ways to incentivize systems to connect patients to a program such as NCCARE360. For example, they could have a chief primary care officer who knows every primary care resource in the community, connects patients to resources, and continues to push for a more robust community health workforce. She added that the most important work is investing in the community and building social service infrastructure. Dr. DeVoe listed some tangible ways to accomplish this, including dashboards in the health care setting to follow SDOH (e.g., housing, food security) in the community and track progress.

  Dr. DeVoe noted that while screening is an important tool, it does miss people; often, the people who have the most social needs don't interact with the health care system and are thereby missed by standard screenings. She additionally emphasized that efforts to address social deprivation in communities often focus on the easiest ways to impact the most people; however, quantity does not equal equity when services are not offered in the best places for communities to access them. She also emphasized the importance of considering social deprivation. She noted that in other countries such as New Zealand, providers can identify a patient's community or place of residence, understand that place's degree of social deprivation, and allocate resources accordingly.

  Dr. DeVoe noted the innovative work from an ACO in Hennepin, Minnesota, (i.e., Hennepin Health ACO) that is going beyond using hospital records and is integrating data from the Department of Corrections, housing agencies, and foster care to address social, medical, dental, and mental health care needs. She noted that the ACO is able to use flexible funds to identify community needs and link patients to primary care, mental health care, and other social services. Dr. DeVoe noted that the ACO has reduced medical expenditures by 11 percent annually for this population and decreased acute care and emergency department (ED) use by almost 10 percent. She added that utilization of outpatient care, primary care, and mental health care has increased. She noted that this is an example where flexible funds used to connect patients to resources showed positive results.

Dr. DeVoe added that current efforts to use payment mechanisms to address SDOH focus on the patient-level with enhanced payments or adjustments for medical complexity. She suggested doing something similar for social vulnerability using geographic-level data to create social deprivation indexes. She added that the Centers for Disease Control and Prevention (CDC) has a vulnerability index that can be implemented for this purpose. Dr. DeVoe suggested paying providers based on patient social vulnerability to prevent adverse selection. Additionally, she noted that health care systems should be rewarded with incentives such as Medicare bonus payments for addressing inequity and SDOH by using data to locate and treat the sickest and most socially vulnerable patients. She added that large health care systems should be incentivized through Medicare and Medicaid payment enhancements to lift up their lowest paid workers through training and education programs.

Dr. DeVoe noted that one way to address people's social needs is with health insurance. She noted that while some patients may qualify early for Medicare based on disabilities, there are inequities in who qualifies early, so most people will not receive any transformative benefits from the Medicare program because they will not likely live to age 65. She recommended that policy makers reconsider who enrolls in Medicare, potentially based on community-level life expectancy.

- Kathleen Noonan emphasized the importance of flexible funding. For example, she noted that the Camden Coalition issued a request for proposals to redesign the standard of care and protocols for emergency care for pregnant women. While the Camden Coalition offered only $10,000, every large health care system and every Federally Qualified Health Center (FQHC) in the area applied. She noted that clients and providers are in inflexible positions, and therefore flexible funding is valuable.

Ms. Noonan noted that it is important to engage with community members and have an ongoing, regular forum for that engagement. During the COVID-19 PHE, her organization learned the importance of listening to community members when it came to choosing a location for a COVID-19 testing site. She noted that in February 2020, the Governor of New Jersey passed regional health hub legislation that gave the Camden Coalition Medicaid 50/50 match dollars to be a convener for multi-sector partners. Through the state, the Coalition is now convening more regularly with community members.

Ms. Noonan noted that Camden Coalition had received a grant to conduct social screening at a number of sites in New Jersey. She suggested that two challenges observed throughout this endeavor are that: 1) the whole care team may not see how the funding is connected to SDOH screening, and 2) staff have expressed ethical concerns with SDOH screening. She emphasized the importance of demonstrating that there are resources available to address these questions.

Ms. Noonan noted that the Camden Coalition has run a regional health information exchange (HIE) since 2010 that also includes shelters, food, and other social services. It has also been running an Aunt Bertha referral platform for seven years. She noted that these services are an important foundation for seeing patterns and creating change. She noted that at the practice level, practices should ask why there are no-show rates so they can better understand their problems. She noted access concerns and that practices should accept walk-ins, schedule child and parent visits and older adult and caregiver visits at the same time, and schedule visits to the

community. She thinks that there is a need for regional platforms and changes to standards of care at the practice level.

Ms. Noonan noted that she does not believe there is any one service provider entity that is best situated to collect SDOH and equity data. She believes everyone should collect data and then collaborate to determine the best way to clean and use it. She emphasized the importance of training all members of the care team in administering and understanding the necessity of screening questions. Ms. Noonan noted the importance of asking the right questions when evaluating models' impact on SDOH, such as improved housing, community involvement, and attending doctors' appointments.

- Charlotte Yeh acknowledged previous comments from Dr. Liao and noted that she believes stakeholders are underutilizing consumer engagement and missing opportunities to engage patients and families when discussing SDOH. She suggested that FFS, in addition to Managed Care and MA, can be used to create value-based care. Dr. Yeh highlighted care coordination programs that included SDOH for Medicare beneficiaries. These programs were able to demonstrate reductions in hospitalizations, ED visits, number of falls, and admissions to long-term care facilities. She added that physicians did not have to track data themselves and were instead tracking the data with multidisciplinary teams through the Medicare plan. Dr. Yeh suggested that this is an untapped opportunity to engage consumers through FFS.

  Dr. Yeh added that if all technical needs are addressed, personal determinants of health (e.g., resiliency, ability to adapt/cope, depression, function) still need to be addressed. Her organization looked at five protective factors (resiliency, purpose, locus of control, optimism, and social connections), and found that for every positive skill that a person had, they had lower depression and anxiety, and more functionality. She added that costs dropped $1,356 per person for every skill the team helped a patient develop.

  Dr. Yeh recommended including ageism in discussions of health equity. She added that a study in the United Kingdom reported that clinicians prescribed digital health tools to people over 65 years of age only 4 percent of the time because there is inherent bias that older adults do not know how to use technology. She noted that data from an AARP survey showed that 72 percent of people 50 and older bought new technology during the pandemic. She added that 77 percent of 70-year-olds have a smart phone that they use daily, but only 5 percent of marketing images show an older person using technology. She suggested that this sort of bias is an important example of why ageism should be added to considerations of health equity.

  Dr. Yeh noted that the COVID-19 PHE highlighted vulnerabilities among older adults and marginalized communities, and underscored hearing loss as a key, typically unrecognized vulnerability. She explained that roughly two-thirds of adults 70 years and older and 40 percent of adults 60 years and older have some hearing loss that is clinically significant. She described how clinically significant hearing loss may complicate patients' use of health care technology and telehealth. She added that Johns Hopkins recently reported that people who are extremely hard of hearing are 46 percent less likely to have a usual source of care, which also impacts people's ability to fill prescriptions and communicate.

  Dr. Yeh discussed ageism in the context of equity, noted that 40 percent of the Medicare supplemental population has a negative perception of aging, and described how this negative

self-perception can increase a patient's risk of hospitalization and related costs. Yet, during the COVID-19 PHE, she noted that while everyone's mental health burden increased, it was highest among young people and lowest among old people. She suggested that this may be because older adults have learned to manage and cope with stress and anxiety. Dr. Yeh also noted that loneliness is the single biggest predictor of dissatisfaction in health care among older adults. She highlighted that the COVID-19 PHE highlighted a focus on the importance of social connection and being in the community.

Dr. Yeh agreed with Ms. Palmer that starting with simple screening questions when assessing SDOH is important. Once simple questions are asked, providers can follow up with patients as needed to obtain more information. It is important that the people asking the questions are comfortable, but she noted that survey data show that people do not want to report that they are lonely or have other social needs because of the related stigma. She noted that her organization has found that using technology to gather these data may be more effective because it is non-judgmental, and people are more likely to report their true needs.

Dr. Yeh suggested that it is important to include caregivers in the discussion of SDOH and related needs. She noted that 53 million adults are caring for children and adults, and seven percent of caregivers are over 75. She emphasized the stress placed on a caregiver, noting that the average caregiver spends 24 hours per week caring for a loved one, and over half of this time is spent advocating for specific care needs. She added that current metrics do not capture the intensity of caregiver burden and recommended the development of metrics assessing this burden.

Dr. Yeh noted that there should be risk adjustments for social and personal vulnerability. She added that time spent addressing social and personal vulnerability should count as a medical expense, but that Medigap currently counts this time as an administrative expense. She cautioned people to measure the work being done but not to shift burden onto caregivers and patients. Lastly, she suggested using risk-reduction models, as well as building patients' personal strength and resiliency to change how aging is viewed.

- Karen Dale noted that member engagement is her highest priority when considering what activities related to addressing SDOH and health equity are useful to improving quality and reducing costs. She explained that AmeriHealth Caritas District of Columbia is working hard to design an insurance product that is valuable to consumers by having conversations with consumers and respecting diverse perspectives. She emphasized the importance of health literacy. She noted that sometimes non-compliance is a result of not understanding the complex health care system. She believes that it is important to ensure that information is provided in simple and clear terms. She also noted that it is important to engage in direct conversations with members to identify barriers to care.

  Ms. Dale emphasized the importance of technology and leveraging tools such as an HIE that can house information for all points of care. She added that it is also important to build in mechanisms so that community-based organizations can access the HIE, which may be a role that managed care organizations and data aggregators can play.

  Ms. Dale agreed that all organizations should help to gather information but cautioned against repeatedly asking patients the same questions. She emphasized that human-centeredness

needs to be included in the design of social risk screening questions to reduce burden. She discussed the importance of building trusting relationships with patients early on. She noted that, while HEDIS measures are currently available and useful for measuring performance, asking open-ended questions would better allow providers to take a more human-centered approach to information gathering and relationship-building.

Ms. Dale believes that focusing on housing and food instability, health literacy, and community employment opportunities will advance SDOH and equity. Ms. Dale noted that organizations such as A Wider Circle are working on ways to promote social cohesion. She thinks that APMs can help advance SDOH and equity by promoting front-end investments and helping to create cohorts of shared services, especially for smaller and mid-sized practices.

Ms. Dale added that there is a need to advocate for the level of insurance coverage that gives people the equal opportunity to be healthy. She recommended advocating for benefits and payment mechanisms to support upfront investments, including in SDOH or in how to pay for social risk factors and their mitigation. She noted that providers may overly focus on medical issues and forget about behavioral or non-medical issues that patients may face; given this, it is important to invest in patients' behavioral health. Ms. Dale noted that models often add to the expectations of providers without removing any burden. She suggested doing a rigorous review of what providers need to do, as well as what they should stop doing.

Public Commenters

Chair Bailet opened the floor for public comments. The following individuals made comments:
1. Jennifer Gasperini (Director of Regulatory Affairs, National Association of Accountable Care Organizations [NAACOS])
2. Jan de Maeseneer, MD, PhD (Professor, Ghent University)

Committee Discussion

Chair Bailet introduced the Committee discussion portion of the public meeting by noting that Committee members would be discussing what they learned from the listening sessions, panelists, public commenters, and background materials provided by the PCDT. He also indicated that the Committee's comments and findings would be synthesized in an RTS on how efforts to address SDOH and equity can be optimized in value-based care and PFPMs. Chair Bailet used a framework of topics to assist Committee members in structuring their conversation.

The Committee members discussed promising approaches for optimizing efforts to address SDOH and health-related social needs in value-based care to improve quality and reduce or control costs.
- Mr. Steinwald remarked that a number of participants mentioned patient-level adjustments for geographically determined social vulnerability. He noted that there is infrastructure for making these adjustments in Medicare using the Geographic Practice Cost Index (GPCI), which is designed to adjust payments for differences in the costs of doing business across locations. He wondered whether there is a way of expanding those adjustments to address vulnerability factors that are not typically built into payment adjustments.
- Chair Bailet agreed that using the GPCI would be a novel approach to payment adjustments.
- Dr. Liao commented that some participants mentioned the value of area-level measures, and Committee members asked several questions related to individual capture. He noted that on the area level, not every individual will have those needs, and it is difficult to capture data on an

individual level. He noted that some studies show that agreement between area- and individual-level data can be as low as 30 or 40 percent. Dr. Liao emphasized the importance of gathering more area- and individual-level data and considering how to braid them, particularly when considering using area-level data for adjustments. He noted that area and individual data will not always agree, and it is unclear how they should be used and in what sequence. He emphasized that this type of adjustment could improve quality of care.

- Dr. Feldstein noted that data should be focused on the individual patient and not necessarily the needs of the provider community. He emphasized the importance of providing patient-centered care and avoiding making programs easy for providers to administer without addressing the root cause of the problem and patient-centered needs.
- Dr. Liao emphasized that promising approaches are likely to vary based on population, specialty, practice size, geographic area, and discipline. He noted that multiple participants commented that practices or organizations could be harmed under payment incentives, and payment incentives should consider urban versus rural practices and practice size. Dr. Liao noted that if differences among individuals and communities are somewhat mediated by type of organization, it will be important to consider how promising approaches vary. Dr. Liao noted that two different organizations—a large regional center where people travel across areas to receive care for certain conditions versus more rural providers—could show very different area-level measures of deprivation.
- Dr. Patel commented that much of the information used by the health care system comes within the health care system itself. She noted that individuals spend the majority of their time outside the health care system (i.e., at home, at work, in the community), and there should be a way to capture data in these other settings. Dr. Patel emphasized that community organizations know their communities and the individuals in them much better than health care providers. She noted that providers do not have the time to interface with patients in a space that feels less hierarchical.

The Committee members discussed challenges related to beneficiary and caregiver needs.
- Chair Bailet highlighted the importance of including ageism in discussions about equity, particularly relating to assumptions about older adults' use of technology. He cited survey data indicating 72 of individuals 50 and older purchased new technology in the midst of the COVID pandemic, and 77 percent of older adults have a smartphone that they use on a daily basis. He encouraged reconsidering assumptions regarding aging. Chair Bailet also commented on his experience as an ear, nose, and throat (ENT) physician having observed the isolation caused by hearing loss. He noted that 46 percent of individuals with hearing loss are less likely to seek care due to hearing issues, which can be mediated by technology that can help those individuals communicate.
- Chair Bailet noted that it is difficult to quantify caregiver burden in dollar amounts. He noted that supportive nursing care is not covered by insurance, and SNFs and assisted living facilities all place significant financial burden on the caregiver community. He wondered if there is a way to assess caregiver financial burden and to assist caregivers either through different funding or care structures.
- Dr. Feldstein raised the issue of how to build a sustainable revenue stream to finance ongoing infrastructure for addressing SDOH and equity. He questioned whether resources could be reallocated from funding for traditional medical care, whether additional revenue streams are needed, or whether measures addressing SDOH and equity could be self-financed through cost savings (i.e., decreased hospitalizations or ED visits).

- Chair Bailet noted that the figure from the PCDT presentation (slide 5) showed that approximately 20 percent of an individual's overall health comes from the health care they receive. He noted that when behavioral health is embedded in primary care practices, patients' overall sense of well-being increases because they can access these services in the same clinical setting. He emphasized the importance of inculcating SDOH into the medical lexicon so they are not thought of as something separate, which makes it difficult to gain access to funding.

The Committee members discussed challenges related to provider needs, including community-based organizations.

- Dr. Liao noted that capturing individual-level data in a comprehensive and shareable way is difficult in the context of how health care is delivered in many settings. He noted that using area-level measures to adjust how providers are compensated in models appears to be much harder than having providers use Z codes to capture data or screen for SDOH. He wondered whether there are other ways to work with community organizations to not only develop new measures, but also take a broader approach to capturing data so that these tasks are not all a provider's responsibility.
- Chair Bailet noted that addressing SDOH and equity places a significant burden on providers, who are tasked with knowing what services are available in their communities, determining which services patients need, referring patients to these services, and following up to ensure patients received the services they need. He noted that physicians may not be in the best position to facilitate this process, and more infrastructure is needed to ensure that all of these steps happen without being shouldered entirely by clinicians.
- Chair Bailet noted that some communities face challenges with siloed activities and duplicative resource expenditure. He noted that what he has observed to be effective is health care systems leveraging their unique expertise so that not every system, provider, or clinic is having to do the same thing. Health care systems can coordinate activities and resources so that individual entities are adding the most value. Chair Bailet noted that physicians should be part of the care teams and communities addressing SDOH, but not the primary entity responsible; this responsibility should fall within the communities themselves.
- Terry Mills remarked that in such a large, enmeshed system of care, every step in the health care system—from first interacting with the patient to evaluating effectiveness and responding to gaps in care—needs to happen in order to realize improvements in community health. He agreed with Chair Bailet that physicians should be a part of this system, but not the center of it.
- Mr. Steinwald noted that as the upstream origins of SDOH are addressed, spending is pushed beyond what is considered traditional health care spending. He questioned how to tap into the $3.6 trillion of traditional health care spending to provide nontraditional services to address SDOH, yet have a significant impact on patient health and costs of care.
- Chair Bailet noted that those investments will not be made without reliable measures to track the effectiveness of SDOH initiatives. He commented that the challenges around measuring progress revolve around what those measurements are, and who is collecting and reporting the data. Chair Bailet noted that one of the participants mentioned that instead of creating new measures for SDOH, measures that already exist should be adjusted. He agreed with limiting and standardizing measure sets to avoid further burdening providers.
- Chair Bailet noted the need for flexible, upfront infrastructure payments and suggested potentially earmarking funds to create community infrastructure for addressing SDOH and equity.

- Dr. Liao remarked on the diversity of participants' experiences, which speaks to the multifaceted issues surrounding SDOH and equity. He emphasized the importance of evaluating payment models' effectiveness in addressing SDOH and equity. He noted that while models should be flexible, certain flexibilities may create challenges in evaluating downstream effects.
- Chair Bailet agreed that addressing SDOH and equity will require a multifaceted, patient-centered approach, as not all individuals face the same social needs. He noted that the health care system would benefit from more investment in addressing SDOH and equity.
- Dr. Liao commented that one of his main takeaways from the discussion was that SDOH is not monolithic, nor is it a "laundry list;" SDOH arise from the intersectionality of different individual needs and community contexts. He noted that the challenges discussed at the meeting, such as designing payment models that provide flexibility but are still evaluable, are important to address, as they will only become more complex if deferred.

Closing Remarks

Chair Bailet thanked the Committee members, presenters, panelists, and the public for their contributions to the meeting. He noted that they explored many facets of SDOH and equity, including the types of relationships needed to be able to better connect health care providers with their local community-based organizations to address social needs; the data needed to measure progress; and how payment approaches can incorporate equity and drive improvement in health care outcomes. Chair Bailet announced that a Request for Input (RFI) on SDOH and equity would be posted on the ASPE PTAC website and sent to the PTAC listserv.

Chair Bailet acknowledged that this was his last public meeting serving as PTAC Chair and noted that this was also Dr. Patel's last public meeting as a Committee member. He thanked Committee members and ASPE leadership and staff for their support. He also announced that PTAC Vice Chair Paul Casale would be the new PTAC Chair, and that Ms. Hardin would be the new PTAC Vice Chair.

The public meeting adjourned at 3:47 p.m. EDT.

Approved and certified by:

//Lisa Shats//   12/20/2021

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*Lisa Shats, Designated Federal Officer   Date
Physician-Focused Payment Model Technical
Advisory Committee

* Lisa Shats certified the minutes in the previous Chair's absence.